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8 **BEFORE THE**  
9 **BOARD OF REGISTERED NURSING**  
10 **DEPARTMENT OF CONSUMER AFFAIRS**  
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No. **2010-658**

13 **CHRISTINE ANN WORRELL**  
6633 County Hwy 15  
14 Rayland, OH 43943  
Registered Nurse License No. 612238

**A C C U S A T I O N**

15 Respondent.

16 Complainant alleges:

17 **PARTIES**

18 1. Louise R. Bailey, M.Ed., RN ("Complainant") brings this Accusation solely in her  
19 official capacity as the Interim Executive Officer of the Board of Registered Nursing ("Board"),  
20 Department of Consumer Affairs.

21 2. On or about January 24, 2003, the Board issued Registered Nurse License Number  
22 612238 to Christine Ann Worrell ("Respondent"). Respondent's registered nurse license was in  
23 full force and effect at all times relevant to the charges brought herein and will expire on June 30,  
24 2012, unless renewed.

25 **STATUTORY AND REGULATORY PROVISIONS**

26 3. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that  
27 the Board may discipline any licensee for any reason provided in Article 3 (commencing with  
28 section 2750) of the Nursing Practice Act.

1        4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not  
2        deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or  
3        to render a decision imposing discipline on the license. Under Code section 2811, subdivision  
4        (b), the Board may renew an expired license at any time within eight years after the expiration.

5        5. Code section 2761 states, in pertinent part:

6                The board may take disciplinary action against a certified or licensed  
7                nurse or deny an application for a certificate or license for any of the following:

8                (a) Unprofessional conduct, which includes, but is not limited to, the  
9                following:

10                (1) Incompetence, or gross negligence in carrying out usual certified or  
11                licensed nursing functions. . .

12        6. California Code of Regulations, title 16, section ("Regulation") 1442 states:

13                As used in Section 2761 of the code, 'gross negligence' includes an  
14                extreme departure from the standard of care which, under similar circumstances,  
15                would have ordinarily been exercised by a competent registered nurse. Such an  
16                extreme departure means the repeated failure to provide nursing care as required or  
17                failure to provide care or to exercise ordinary precaution in a single situation which  
18                the nurse knew, or should have known, could have jeopardized the client's health or  
19                life.

20        7. Regulation 1443 states:

21                As used in Section 2761 of the code, "incompetence" means the lack of  
22                possession of or the failure to exercise that degree of learning, skill, care and  
23                experience ordinarily possessed and exercised by a competent registered nurse as  
24                described in Section 1443.5.

25        8. Regulation 1443.5 states, in pertinent part:

26                A registered nurse shall be considered to be competent when he/she  
27                consistently demonstrates the ability to transfer scientific knowledge from social,  
28                biological and physical sciences in applying the nursing process, as follows:

29                . . . .  
30                (5) Evaluates the effectiveness of the care plan through observation of the  
31                client's physical condition and behavior, signs and symptoms of illness, and reactions  
32                to treatment and through communication with the client and health team members,  
33                and modifies the plan as needed.

34                (6) Acts as the client's advocate, as circumstances require, by initiating  
35                action to improve health care or to change decisions or activities which are against the  
36                interests or wishes of the client, and by giving the client the opportunity to make  
37                informed decisions about health care before it is provided.

1 **COST RECOVERY**

2 9. Code section 125.3 provides, in pertinent part, that the Board may request the  
3 administrative law judge to direct a licensee found to have committed a violation or violations of  
4 the licensing act to pay a sum not to exceed the reasonable costs of the investigation and  
5 enforcement of the case.

6 **FIRST CAUSE FOR DISCIPLINE**

7 **(Gross Negligence)**

8 10. At all times relevant herein, Respondent was employed as a registered nurse at Shasta  
9 Regional Medical Center in Redding, California.

10 11. On or about April 1, 2007, patient M. M. was admitted to the medical center,  
11 complaining of vomiting for the last 24 hours.<sup>1</sup> The patient was initially treated in the emergency  
12 department ("ED") and was placed on 2 liters of oxygen as her oxygen saturation level was 94%.  
13 The patient was noted as having normal respiratory effort and there were no signs and symptoms  
14 of shortness of breath (SOB). The ED nurse documented that the patient had black emesis at  
15 22:11 and 22:13 hours. Dr. L. ordered Zofran 4 mg by IV every 4 hours as needed for nausea and  
16 vomiting. Dr. L. documented that while the patient was in the ED, the emesis stopped after  
17 administration of the antiemetic and the patient did not complain of nausea. Dr. L. issued a transfer  
18 order that the patient was to be assigned to a medical floor with telemetry monitoring. The  
19 patient was later admitted to the oncology floor close to the nurse's station.

20 12. On April 2, 2007, at approximately 00:15 hours, Respondent assumed care of the  
21 patient, completed an initial assessment, and documented the patient's vital signs as pulse rate  
22 112, respiration 24, blood pressure 151/82, and oxygen saturation level 90% at 2 liters.  
23 Respondent's problem list included vomiting/coffee ground emesis and her goal of care was that  
24 the patient was to be free of nausea and vomiting by providing clear liquids and antiemetics as  
25 needed. Respondent documented that the patient was "somewhat SOB" at rest and increased the  
26 patient's oxygen to 3 liters.

27 <sup>1</sup> The patient had previously been hospitalized at the medical center for gastrointestinal  
28 bleeding, and her first admission was from September 26, 2006, to September 29, 2006.

1        13. Respondent is subject to disciplinary action pursuant to Code section 2761,  
2 subdivision (a)(1), on the grounds of unprofessional conduct, in that on or about April 2, 2007,  
3 Respondent was guilty of gross negligence in her care of M. M. within the meaning of Regulation  
4 1442, as follows: At approximately 01:00 hours, Respondent documented in the medical records  
5 that the patient had 20 cc of black emesis, but denied nausea. At approximately 02:45 hours,  
6 Respondent documented that the patient had 60 cc of back emesis and administered Zofran 4 mg  
7 to the patient. At approximately 04:00 hours, Respondent documented that the patient continued  
8 to have some liquid emesis and indicated on the intake and output sheet that the patient had 25 ml  
9 of emesis at 04:00 hours and 60 ml at 05:00 hours. Respondent failed to notify Dr. L. or another  
10 medical doctor about the patient's persistent vomiting, the continued black color of the vomit, or  
11 the increased use of oxygen, as above.

12                                    **SECOND CAUSE FOR DISCIPLINE**

13                                    **(Incompetence)**

14        14. Complainant incorporates by reference as though fully set forth herein the allegations  
15 contained in paragraphs 10 through 13 above.

16        15. Respondent is subject to disciplinary action pursuant to Code section 2761,  
17 subdivision (a)(1), on the grounds of unprofessional conduct, in that on or about April 2, 2007,  
18 Respondent was guilty of incompetence in her care of patient M. M. within the meaning of  
19 Regulation 1443, as follows:

20        a. Respondent increased the patient's oxygen to 3 liters, but failed to document in the  
21 medical records whether this intervention was effective in raising the patient's oxygen saturation  
22 level or in decreasing the patient's shortness of breath.

23        b. Respondent failed to take the next set of vital signs on the patient until 07:00 hours,  
24 despite the fact that the patient's initial vital signs were abnormal and the fact that the patient was  
25 on a telemetry monitor.

26        ///

27        ///

28        ///

1 THIRD CAUSE FOR DISCIPLINE

2 (Unprofessional Conduct)

3 16. Complainant incorporates by reference as though fully set forth herein the allegations  
4 contained in paragraphs 10 through 13 above.

5 17. Respondent is subject to disciplinary action pursuant to Code section 2761,  
6 subdivision (a), in that on or about April 2, 2007, Respondent committed acts constituting  
7 unprofessional conduct in her care of patient M. M., as set forth in paragraphs 13 and 15 above.

8 PRAYER

9 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,  
10 and that following the hearing, the Board of Registered Nursing issue a decision:

11 1. Revoking or suspending Registered Nurse License Number 612238, issued to  
12 Christine Ann Worrell;

13 2. Ordering Christine Ann Worrell to pay the Board of Registered Nursing the  
14 reasonable costs of the investigation and enforcement of this case, pursuant to Business and  
15 Professions Code section 125.3;

16 3. Taking such other and further action as deemed necessary and proper.

17  
18 DATED: 6/22/10

Louise R. Bailey  
LOUISE R. BAILEY, M.ED., RN  
Interim Executive Officer  
Board of Registered Nursing  
Department of Consumer Affairs  
State of California  
Complainant

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